

January 1–December 31, 2022

# 2022 Summary of Benefits

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## Kaiser Permanente Medicare Advantage Plans:

- Kaiser Permanente Medicare Advantage Value DC Plan (HMO)
- Kaiser Permanente Medicare Advantage Standard DC Plan (HMO)
- Kaiser Permanente Medicare Advantage High DC Plan (HMO)

*These plans include Medicare Part D prescription drug coverage*



## About this Summary of Benefits

Thank you for considering Kaiser Permanente Medicare Advantage. You can use this **Summary of Benefits** to learn more about our plans. It includes information about:

- Premiums
- Benefits and costs
- Part D prescription drugs
- Optional supplemental benefits (Advantage Plus)
- Additional benefits
- Who can enroll
- Coverage rules
- Getting care

For definitions of some of the terms used in this booklet, see the glossary at the end.

### For more details

This document is a summary of 3 Kaiser Permanente Medicare Advantage plans that include Medicare Part D prescription drug coverage. It doesn't include everything about what's covered and not covered or all the plan rules. For details, see the **Evidence of Coverage (EOC)**, which is located on our website at [kp.org/eocmasma](https://kp.org/eocmasma) or ask for a copy from Member Services by calling **1-888-777-5536** (TTY 711), 7 days a week, 8 a.m. to 8 p.m.

We also offer a plan without Part D drug coverage. If you'd like information about our other plan, call **1-877-408-8607** (TTY 711), 8 a.m. to 8 p.m., 7 days a week or go to [kp.org/medicare](https://kp.org/medicare).

### Have questions?

- If you're not a member, please call **1-877-408-8607** (TTY 711).
- If you're a member, please call Member Services at **1-888-777-5536** (TTY 711).
- 7 days a week, 8 a.m. to 8 p.m.

## What's covered and what it costs

\*Your plan provider may need to provide a referral

†Prior authorization may be required.

Benefits and premiums	With our Value DC plan, you pay	With our Standard DC plan, you pay	With our High DC plan, you pay
<b>Monthly plan premium</b>	<b>\$0</b>	<b>\$30</b>	<b>\$142</b>
<b>Deductible</b>	<b>None</b>	<b>None</b>	<b>None</b>
<b>Your maximum out-of-pocket responsibility</b> Doesn't include Medicare Part D drugs	<b>\$6,900</b>	<b>\$6,900</b>	<b>\$5,700</b>
<b>Inpatient hospital coverage*†</b> There's no limit to the number of medically necessary inpatient hospital days.	<b>\$300</b> per day for days 1 through 5 of your stay and <b>\$0</b> for the rest of your stay	<b>\$270</b> per day for days 1 through 5 of your stay and <b>\$0</b> for the rest of your stay	<b>\$200</b> per day for days 1 through 5 of your stay and <b>\$0</b> for the rest of your stay
<b>Outpatient hospital coverage*†</b>	<b>\$0–\$300</b> per visit	<b>\$0–\$250</b> per visit	<b>\$0–\$125</b> per visit
<b>Ambulatory Surgery Center*†</b>	<b>\$300</b> per visit	<b>\$250</b> per visit	<b>\$125</b> per visit
<b>Doctor's visits</b>			
• Primary care providers	<b>\$10</b> per visit	<b>\$10</b> per visit	<b>\$5</b> per visit
• Specialists*†	<b>\$50</b> per visit	<b>\$40</b> per visit	<b>\$30</b> per visit
<b>Preventive care*†</b> See the <b>EOC</b> for details.	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Emergency care</b> We cover emergency care anywhere in the world.	<b>\$90</b> per Emergency Department visit	<b>\$90</b> per Emergency Department visit	<b>\$90</b> per Emergency Department visit
<b>Urgently needed services</b> We cover urgent care anywhere in the world.	<b>\$50</b> per office visit	<b>\$40</b> per office visit	<b>\$30</b> per office visit
<b>Diagnostic services, lab, and imaging*†</b>			
• Lab tests	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
• Diagnostic tests and procedures (like EKG)			
• X-rays	<b>\$20</b> per visit	<b>\$15</b> per visit	<b>\$10</b> per visit

<b>Benefits and premiums</b>	<b>With our Value DC plan, you pay</b>	<b>With our Standard DC plan, you pay</b>	<b>With our High DC plan, you pay</b>
<ul style="list-style-type: none"> <li>Other imaging procedures (like MRI, CT, and PET)</li> </ul>	<b>\$200</b> per procedure	<b>\$100</b> per procedure	<b>\$40</b> per procedure
<b>Hearing services*†</b> <ul style="list-style-type: none"> <li>Evaluations to diagnose medical conditions</li> </ul>	<b>\$50</b> per visit	<b>\$40</b> per visit	<b>\$30</b> per visit
<ul style="list-style-type: none"> <li>Hearing aid fitting or evaluation exam</li> </ul>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<ul style="list-style-type: none"> <li>Hearing aids (allowance per ear, every three years)</li> </ul> <p>If you sign up for optional benefits, the allowance is greater (see Advantage Plus for details).</p>	<b>\$500 allowance</b>  If your hearing aid purchase is more than \$500, <b>you pay the difference.</b>	<b>\$500 allowance</b>  If your hearing aid purchase is more than \$500, <b>you pay the difference.</b>	<b>\$500 allowance</b>  If your hearing aid purchase is more than \$500, <b>you pay the difference.</b>
<b>Dental services</b> <ul style="list-style-type: none"> <li>Preventive dental care</li> </ul>	<b>\$30</b> per visit for most preventive care (limited to 2 visits a year for oral exams, teeth cleaning, and bitewing X-rays and 1 fluoride treatment).	<b>\$30</b> per visit for most preventive care (limited to 2 visits a year for oral exams, teeth cleaning, and bitewing X-rays and 1 fluoride treatment).	<b>\$30</b> per visit for most preventive care (limited to 2 visits a year for oral exams, teeth cleaning, and bitewing X-rays and 1 fluoride treatment).
<ul style="list-style-type: none"> <li>Comprehensive dental care*†</li> </ul>	The amount you pay varies depending on the service, see the <b>EOC</b> for details.	The amount you pay varies depending on the service, see the <b>EOC</b> for details.	The amount you pay varies depending on the service, see the <b>EOC</b> for details.
<b>Vision services*†</b> <ul style="list-style-type: none"> <li>Visits to diagnose and treat eye diseases and conditions</li> <li>Routine eye exams</li> </ul>	<ul style="list-style-type: none"> <li><b>\$10</b> per visit with an optometrist</li> <li><b>\$50</b> per visit with an ophthalmologist</li> </ul>	<ul style="list-style-type: none"> <li><b>\$10</b> per visit with an optometrist</li> <li><b>\$40</b> per visit with an ophthalmologist</li> </ul>	<ul style="list-style-type: none"> <li><b>\$5</b> per visit with an optometrist</li> <li><b>\$30</b> per visit with an ophthalmologist</li> </ul>
<ul style="list-style-type: none"> <li>Preventive glaucoma screening and diabetic retinopathy services</li> </ul>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<ul style="list-style-type: none"> <li>Eyeglasses or contact lenses after cataract surgery</li> </ul>	<b>20%</b> coinsurance up to Medicare's limit and you pay any amounts beyond that limit.	<b>20%</b> coinsurance up to Medicare's limit and you pay any amounts beyond that limit.	<b>20%</b> coinsurance up to Medicare's limit and you pay any amounts beyond that limit.

<b>Benefits and premiums</b>	<b>With our Value DC plan, you pay</b>	<b>With our Standard DC plan, you pay</b>	<b>With our High DC plan, you pay</b>
<ul style="list-style-type: none"> <li>Other eyewear (allowance every two years).</li> </ul> <p>If you sign up for optional benefits, the allowance is greater (see Advantage Plus for details).</p>	If your eyewear costs more than \$200, <b>you pay the difference.</b>	If your eyewear costs more than \$250, <b>you pay the difference.</b>	If your eyewear costs more than \$250, <b>you pay the difference.</b>
<b>Mental health services*†</b> <ul style="list-style-type: none"> <li>Outpatient group therapy</li> </ul>	<b>\$10</b> per visit	<b>\$10</b> per visit	<b>\$5</b> per visit
<ul style="list-style-type: none"> <li>Outpatient individual therapy</li> </ul>	<b>\$20</b> per visit	<b>\$20</b> per visit	<b>\$10</b> per visit
<b>Skilled nursing facility*†</b> We cover up to 100 days per benefit period.	<b>Per benefit period:</b> <ul style="list-style-type: none"> <li><b>\$0</b> per day for days 1 through 20</li> <li><b>\$188</b> per day for days 21 through 100</li> </ul>	<b>Per benefit period:</b> <ul style="list-style-type: none"> <li><b>\$0</b> per day for days 1 through 20</li> <li><b>\$188</b> per day for days 21 through 100</li> </ul>	<b>Per benefit period:</b> <ul style="list-style-type: none"> <li><b>\$0</b> per day for days 1 through 20</li> <li><b>\$150</b> per day for days 21 through 100</li> </ul>
<b>Physical therapy*†</b>	<b>\$40</b> per visit	<b>\$40</b> per visit	<b>\$30</b> per visit
<b>Ambulance</b>	<b>\$275</b> per one-way trip	<b>\$275</b> per one-way trip	<b>\$225</b> per one-way trip
<b>Transportation</b> We cover up to 24 one-way trips per calendar year to take you to and from a network provider.	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Medicare Part B drugs†</b> A limited number of Medicare Part B drugs are covered when you get them from a plan provider. See the <b>EOC</b> for details and the <b>Pharmacy Directory</b> for preferred and standard plan pharmacy locations. <ul style="list-style-type: none"> <li>Drugs that must be administered by a health care professional</li> </ul>	<b>\$0 or 20%</b> coinsurance depending on the drug.	<b>\$0 or 20%</b> coinsurance depending on the drug.	<b>\$0 or 20%</b> coinsurance depending on the drug.
<ul style="list-style-type: none"> <li>Up to a 30-day supply of a generic drug</li> </ul>	<ul style="list-style-type: none"> <li><b>\$15</b> at a preferred plan pharmacy</li> <li><b>\$20</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li><b>\$15</b> at a preferred plan pharmacy</li> <li><b>\$20</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li><b>\$15</b> at a preferred plan pharmacy</li> <li><b>\$20</b> at a standard plan pharmacy</li> </ul>

Benefits and premiums	With our Value DC plan, you pay	With our Standard DC plan, you pay	With our High DC plan, you pay
<ul style="list-style-type: none"> <li>Up to a 30-day supply of a brand-name drug</li> </ul>	<ul style="list-style-type: none"> <li><b>\$45</b> at a preferred plan pharmacy</li> <li><b>\$47</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li><b>\$45</b> at a preferred plan pharmacy</li> <li><b>\$47</b> at a standard plan pharmacy</li> </ul>	<ul style="list-style-type: none"> <li><b>\$42</b> at a preferred plan pharmacy</li> <li><b>\$47</b> at a standard plan pharmacy</li> </ul>

## Medicare Part D prescription drug coverage†

The amount you pay for drugs will be different depending on:

- The plan you enroll in (Value, Standard, or High).
- The tier your drug is in. There are 6 drug tiers. To find out which of the 6 tiers your drug is in, see our Part D formulary at **kp.org/seniorrx** or call Member Services to ask for a copy at **1-888-777-5536 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.
- The day supply quantity you get (like a 30-day or 90-day supply). Note: A supply greater than a 30-day supply isn't available for all drugs.
- The type of plan pharmacy that fills your prescription (preferred pharmacy, standard pharmacy, or our mail-order pharmacy). To find our pharmacy locations, see the **Pharmacy Directory** at **kp.org/directory**. Note: Not all drugs can be mailed.
- The coverage stage you're in (deductible, initial, coverage gap, or catastrophic coverage stages).

### Deductible stage

Because we have no deductible, this payment stage does not apply to you and you start the year in the initial coverage stage.

## Initial coverage stage

You pay the copays and coinsurance shown in the chart below for up to a 30-day supply until your total yearly drug costs reach **\$4,430**. (Total yearly drug costs are the amounts paid by both you and any Part D plan during a calendar year.) If you reach the \$4,430 limit in 2022, you move on to the coverage gap stage and your coverage changes.

Drug tier	Preferred plan pharmacy			Standard plan pharmacy
	Up to a 30-day supply			
	Value plan	Standard plan	High plan	All plans
<b>Tier 1</b> (Preferred generic)	<b>\$5</b>	<b>\$3</b>	<b>\$5</b>	<b>\$10</b>
<b>Tier 2</b> (Generic)	<b>\$15</b>	<b>\$15</b>	<b>\$15</b>	<b>\$20</b>
<b>Tier 3</b> (Preferred brand-name)	<b>\$45</b>	<b>\$45</b>	<b>\$42</b>	<b>\$47</b>
<b>Tier 4</b> (Nonpreferred brand-name)	<b>\$100</b>	<b>\$100</b>	<b>\$80</b>	<b>\$100</b>
<b>Tier 5</b> (Specialty)	<b>33% coinsurance</b>			
<b>Tier 6</b> (Vaccines)	<b>\$0</b>			

### 31- to 90-day supply of drugs

You pay **\$0** for a 31- to 90-day supply of drugs in Tier 1 from our preferred mail-order pharmacy.

For all other prescriptions, the copays listed above in the chart will be multiplied as follows:

- If you get a 31- to 60-day supply from one of our retail pharmacies or standard mail-order pharmacy, you pay 2 copays.
- If you get a 61- to 90-day supply from one of our retail pharmacies or standard mail-order pharmacy, you pay 3 copays.
- If you get a 31- to 90-day supply of drugs in Tiers 2, 3, or 4 from our preferred mail-order pharmacy, you pay 2 copays.

**Note:** For a 31- to 90-day supply of drugs subject to a coinsurance, you pay the coinsurance listed above in the chart.



## Coverage gap stage

The coverage gap stage begins if you or a Part D plan spends **\$4,430** on your drugs during 2022. You pay the following copays and coinsurance during the coverage gap stage:

Drug tier	With our Standard or Value plan, you pay	With our High plan, you pay
<b>Tiers 1 and 2</b>	<b>25%</b> coinsurance	The same copays listed above that you pay during the initial coverage stage
<b>Tiers 3, 4, and 5</b>	<b>25%</b> coinsurance	<b>25%</b> coinsurance
<b>Tier 6</b>	<b>\$0</b>	<b>\$0</b>

## Catastrophic coverage stage

If you spend **\$7,050** on your Part D prescription drugs in 2022, you'll enter the catastrophic coverage stage. Most people never reach this stage, but if you do, your copays and coinsurance will change for the rest of 2022. You pay the following per prescription during the catastrophic coverage stage:

- **5%** coinsurance for generic or brand-name drugs
- **\$0** for Part D vaccines

## Long-term care, plan home-infusion, and non-plan pharmacies

- If you live in a **long-term care facility** and get your drugs from their pharmacy, you pay the same as at a standard plan pharmacy and you can get up to a 31-day supply.
- Covered Part D **home infusion** drugs from a plan home-infusion pharmacy are provided at no charge.
- If you get covered Part D drugs from a non-plan pharmacy, you pay the same as at a standard plan pharmacy and you can get up to a 30-day supply. Generally, we cover drugs filled at a non-plan pharmacy only when you can't use a network pharmacy, like during a disaster. See the **Evidence of Coverage** for details.

## Advantage Plus (optional benefits)

In addition to the benefits that come with your plan, you can choose to buy a supplemental benefit package called Advantage Plus. Advantage Plus gives you extra coverage for an additional monthly cost that's added to your monthly plan premium. See the **Evidence of Coverage** for details

Advantage Plus benefits and premiums	You pay
<b>Additional monthly premium</b>	<b>\$25</b>
<b>Additional eyewear allowance*†</b> Every 24 months, a \$175 allowance is added to the eyewear allowance described in "Vision services" above.	If your eyewear costs more than the combined allowance of \$425 for High or Standard plan members or \$375 for Value plan members, <b>you pay the difference.</b>
<b>Hearing aids*†</b> Every 3 years, a \$1,000 allowance is added to the hearing aid allowance described in "Hearing services" above to buy 1 aid, per ear.	If your hearing aid costs more than the combined allowance of \$1,500 per ear, <b>you pay the difference.</b>
<b>Dental services</b> • Preventive	<b>\$10</b> per visit for oral exams, 2 teeth cleanings, 1 fluoride treatment, and X-rays.
• Comprehensive	The amount you pay varies depending on the service, see the <b>EOC</b> for details.

## Additional benefits

These benefits are available to you as a plan member:	Value DC plan, you pay	Standard DC plan, you pay	High DC plan, you pay
<b>Fitness benefit — The Silver&amp;Fit® Program</b> You pay no additional cost for standard membership to any of the participating fitness centers in the Silver&Fit program. You can also choose one Home Fitness Kit from a selection of kits to help you stay fit at home.  The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. Participating fitness centers and fitness chains may vary by location and are subject to change.	Not covered.	<b>\$0</b>	<b>\$0</b>
<b>Over-the-counter (OTC) items</b> We cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items each quarter of the year	<b>\$0</b> up to the <b>\$30</b> quarterly benefit limit.	<b>\$0</b> up to the <b>\$50</b> quarterly benefit limit.	<b>\$0</b> up to the <b>\$60</b> quarterly benefit limit.

These benefits are available to you as a plan member:	Value DC plan, you pay	Standard DC plan, you pay	High DC plan, you pay
<p>(January, April, July, October) up to the quarterly benefit limit shown in the right column. The catalog lists the price of each item. Each order must be at least \$20. Any unused portion of the quarterly benefit limit doesn't carry forward to the next quarter.</p> <p>To view our catalog and place an order online, please visit <b>kp.org/otc/mas</b>. You may place an order over the phone or request a printed catalog be mailed to you by calling <b>1-833-881-1422 (TTY 711)</b>, 9 a.m. to 7 p.m., Monday through Friday.</p>			
<p><b>Medicare Explorer by Kaiser Permanente (outside service area benefit)</b></p> <p>If you travel outside any Kaiser Permanente service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed a benefit maximum of \$1,200 in covered plan charges per calendar year.</p> <p>Covered services, include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Certain preventive services covered at <b>\$0</b> under Original Medicare.</li> <li>• Primary care and specialty care visits.</li> <li>• Outpatient diagnostic tests and therapeutic services and supplies.</li> <li>• X-rays and other basic imaging.</li> <li>• Mental health care outpatient visits.</li> <li>• Medicare Part B drugs.</li> </ul> <p>For coverage details, including a full list of covered services, how to locate an eligible provider, how to schedule an appointment, claims, and how to determine if you are outside a Kaiser Permanente service area, please see the Medical Benefits Chart, Chapter 4, in the <b>Evidence of Coverage</b>.</p>	<p>You pay the following up to the <b>\$1,200</b> annual benefit limit:</p> <ul style="list-style-type: none"> <li>• <b>\$50</b> per specialty care visit.</li> <li>• <b>\$50</b> per visit for physical, speech, and occupational therapy.</li> <li>• <b>\$25</b> per visit for X-rays and other basic imaging.</li> <li>• <b>\$25</b> per mental health care or substance abuse individual therapy visit or \$15 per mental health care or substance abuse group therapy visit.</li> <li>• <b>\$20</b> per primary care visit.</li> <li>• <b>\$10</b> per visit for lab tests.</li> <li>• <b>\$10</b> per visit for EKGs, holter monitoring, and EEGs.</li> <li>• <b>\$10</b> for blood, including storage and administration.</li> <li>• <b>\$0</b> for preventive care visits.</li> <li>• <b>\$20</b> for telehealth visits.</li> <li>• You pay <b>20% coinsurance</b> for Medicare Part B drugs administered in an office or clinic.</li> </ul> <p>Once you reach the maximum plan benefit coverage amount of <b>\$1,200</b> per calendar year, you pay any amounts that exceed the benefit maximum.</p>		

## Who can enroll

You can sign up for one of our plans if:

- You have both Medicare Part A and Part B. (To get and keep Medicare, most people must pay Medicare premiums directly to Medicare. These are separate from the premiums you pay our plan.)
- You're a citizen or lawfully present in the United States.
- You live in the service area, which is the District of Columbia.

## Coverage rules

We cover the services and items listed in this document and the **Evidence of Coverage**, if:

- The services or items are medically necessary.
- The services and items are considered reasonable and necessary according to Original Medicare's standards.
- You get all covered services and items from plan providers listed in our **Provider Directory** and **Pharmacy Directory**. But there are exceptions to this rule. We also cover:
  - Care from plan providers in another Kaiser Permanente Region
  - Emergency care
  - Out-of-area dialysis care
  - Out-of-area urgent care (covered inside the service area from plan providers and in rare situations from non-plan providers)
  - Referrals to non-plan providers if you got approval in advance (prior authorization) from our plan in writing

Note: You pay the same plan copays and coinsurance when you get covered care listed above from non-plan providers. If you receive non-covered care or services, you must pay the full cost.

For details about coverage rules, including non-covered services (exclusions), see the **Evidence of Coverage**.

## Getting care

At most of our plan facilities, you can usually get all the covered services you need, including specialty care, pharmacy, and lab work. To find our provider locations, see our **Provider Directory** or **Pharmacy Directory** at [kp.org/directory](http://kp.org/directory) or ask us to mail you a copy by calling Member Services at 1-888-777-5536 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

## Your personal doctor

Your personal doctor (also called a primary care physician) will give you primary care and will help coordinate your care, including hospital stays, referrals to specialists, and prior authorizations. Most personal doctors are in internal medicine or family practice. You must choose one of our available plan

providers to be your personal doctor. You can change your doctor at any time and for any reason. You can choose or change your doctor by calling Member Services or at **kp.org**.

## **Help managing conditions**

If you have more than 1 ongoing health condition and need help managing your care, we can help. Our case management programs bring together nurses, social workers, and your personal doctor to help you manage your conditions. The program provides education and teaches self-care skills. If you're interested, please ask your personal doctor for more information.

## **Notices**

### **Appeals and grievances**

You can ask us to provide or pay for an item or service you think should be covered. If we say no, you can ask us to reconsider our decision. This is called an appeal. You can ask for a fast decision if you think waiting could put your health at risk. If your doctor agrees, we'll speed up our decision.

If you have a complaint that's not about coverage, you can file a grievance with us. See the **Evidence of Coverage** for details about the processes for making complaints and making coverage decisions and appeals, including fast or urgent decisions for drugs, services, or hospital care.

### **Kaiser Foundation Health Plan**

Kaiser Foundation Health Plan of the Mid-Atlantic States is a nonprofit corporation and a Medicare Advantage plan called Kaiser Permanente Medicare Advantage. We offer several Kaiser Permanente Medicare Advantage plans in our Mid-Atlantic States Region's service area, which includes the District of Columbia and specified areas in Maryland and Virginia.

Each plan has different benefits, copays, coinsurance, premiums, and plan service areas. But you can get care from plan providers anywhere in our Mid-Atlantic States Region.

If you move from your plan's service area to another service area in our Mid-Atlantic States Region, you'll have to enroll in a Kaiser Permanente Medicare Advantage plan in your new service area.

### **Language assistance services**

#### **English**

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-777-5536** (TTY: **711**).

#### **Spanish**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-777-5536** (TTY: **711**).

#### **Chinese**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-777-5536**（TTY：**711**）。

#### **Vietnamese**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Gọi số **1-888-777-5536** (TTY: **711**).

### Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-777-5536** (TTY: **711**).

### Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

**1-888-777-5536**(TTY: **711**)번으로 전화해 주십시오.

### Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-777-5536** (телетайп: **711**).

### Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-777-5536** (TTY: **711**) まで、お電話にてご連絡ください。

### Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-888-777-5536** (TTY: **711**).

### Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

**1-888-777-5536** (TTY: **711**) पर कॉल करें।

### Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነየትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደሚከተለው ቁጥር ይደውሉ**1-888-777-5536** (መስማት ለተሳናቸው: **711**).

### Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.  
با **1-888-777-5536** (TTY: **711**) تماس بگیرید

### Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم  
**1-888-777-5536** (رقم هاتف الصم والبكم: **711**)

### German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-777-5536** (TTY: **711**).

### French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-777-5536** (ATS : **711**).

### Yoruba

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi  
**1-888-777-5536** (TTY: **711**).

### Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-777-5536** (TTY: **711**).

### Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-777-5536** (TTY: **711**).

### Bengali

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-888-777-5536** (TTY: **711**)।

### Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-888-777-5536** (TTY: **711**).

### French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-777-5536** (TTY: **711**).

### Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-777-5536** (TTY: **711**).

### Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-888-777-5536** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2101 East Jefferson Street, Rockville, MD 20852 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

**<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**.

## Privacy

We protect your privacy. See the **Evidence of Coverage** or view our **Notice of Privacy Practices** on [kp.org/privacy](http://kp.org/privacy) to learn more.

## Helpful definitions (glossary)

### Allowance

A dollar amount you can use toward the purchase of an item. If the price of the item is more than the allowance, you pay the difference.

### Benefit period

The way our plan measures your use of skilled nursing facility services. A benefit period starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't gotten any inpatient hospital care or skilled care in an SNF for 60 days in a row. The benefit period isn't tied to a calendar year. There's no limit to how many benefit periods you can have or how long a benefit period can be.

### Calendar year

The year that starts on January 1 and ends on December 31.

### Coinsurance

A percentage you pay of our plan's total charges for certain services or prescription drugs. For example, a 20% coinsurance for a \$200 item means you pay \$40.

### Copay

The set amount you pay for covered services — for example, a \$20 copay for an office visit.

### Deductible

It's the amount you must pay for Medicare Part D drugs before you will enter the initial coverage stage.

### Evidence of Coverage

A document that explains in detail your plan benefits and how your plan works.

### Maximum out-of-pocket responsibility

The most you'll pay in copays or coinsurance each calendar year for services that are subject to the maximum. If you reach the maximum, you won't have to pay any more copays or coinsurance for services subject to the maximum for the rest of the year.

### Medically necessary

Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

### Non-plan provider

A provider or facility that doesn't have an agreement with Kaiser Permanente to deliver care to our members.

### Plan

Kaiser Permanente Medicare Advantage.

### Plan premium

The amount you pay for your Kaiser Permanente Medicare Advantage health care and prescription drug coverage.



**Plan provider**

A plan or network provider can be a facility, like a hospital or pharmacy, or a health care professional, like a doctor or nurse.

**Preferred pharmacy**

A plan pharmacy where you can get your prescriptions at preferred copays. These pharmacies are usually located at plan medical offices (see the **Pharmacy Directory** for locations). The amount you pay at these pharmacies is less than you pay at other plan pharmacies that only offer standard copays, which are referred to in this document as standard pharmacies.

**Prior authorization**

Some services or items are covered only if your plan provider gets approval in advance from our plan (sometimes called prior authorization). Services or items subject to prior authorization are flagged with a † symbol in this document.

**Region**

A Kaiser Foundation Health Plan organization. We have Kaiser Permanente Regions located in Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

**Retail plan pharmacy**

A plan pharmacy where you can get prescriptions. These pharmacies are usually located at plan medical offices.

**Standard pharmacy**

A plan pharmacy where you can get your prescriptions at standard copays. These pharmacies aren't usually located at plan medical offices (see the **Pharmacy Directory** for locations). The amount you pay at these pharmacies is more than you pay at plan pharmacies that only offer preferred copays, which are referred to in this document as preferred pharmacies.

**Service area**

The geographic area where we offer Kaiser Permanente Medicare Advantage plans. To enroll and remain a member of our plan, you must live in one of our Kaiser Permanente Medicare Advantage plan's service area.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. This contract is renewed annually by the Centers for Medicare & Medicaid Services (CMS). By law, our plan or CMS can choose not to renew our Medicare contract.

For information about Original Medicare, refer to your "**Medicare & You**" handbook. You can view it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.





**[kp.org/medicare](http://kp.org/medicare)**

Kaiser Foundation Health Plan of the Mid-Atlantic States  
2101 East Jefferson Street  
Rockville, MD 20852

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